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Programme Committee
1992 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Papua New Guinea

The Executive Director recommends that the Executive Board approve the country programme of Papua New Guinea for the period 1993-1997 in the amount of $5,260,000 from general resources, subject to the availability of funds, and $5 million in supplementary funds, subject to the availability of specific-purpose contributions.

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* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1991, will be contained in the "Summary of 1992 recommendations for general resources and supplementary funding programmes" (E/ICEF/1992/P/L.2 and Add.1).

THE SITUATION OF CHILDREN AND WOMEN

1. With a population estimated at 3.9 million in 1990, Papua New Guinea lies in the south-west Pacific and has a total land area of 462,840 square kilometres. Its topography is among the most rugged in the world, resulting in isolation in many parts of the country. Only about 30 per cent of the land is arable, largely owned by tribes or clans. These tribes and clans, the basic social organization of the population, present a mosaic of cultures, as reflected in the existence of over 700 different languages. Cultural differences and land claims often lead to inter-tribal conflicts, which have impeded the development of basic services.

2. Approximately 85 per cent of the population is engaged in subsistence farming or the raising of cash crops. Exports of primary commodities, such as minerals, are the main source of foreign exchange. The early 1990 closing of the copper mine at Bougainville has caused an economic and financial crisis, since the mine provided for 35 per cent of total export earnings. The Government has made some adjustment measures, which include cuts in government expenditures and retraining of retrenched staff, who are then redeployed to the private sector. To offset the social costs of adjustment, a special intervention programme has been planned, covering projects in housing, health services and the development of small industries, for which the Government will seek assistance from the donor community.

3. Of the total population, children under five years of age account for 15 per cent and children under 15 years of age account for 43 per cent. Over the last decade, the infant mortality rate (IMR) decreased from 80 per 1,000 live births in 1980 to 56 per 1,000 live births in 1990, and the under-five mortality rate (U5MR) decreased from 112 per 1,000 live births in 1980 to 80 per 1,000 live births in 1990. There is, however, great variation between and within provinces, with IMRs ranging from 30 per 1,000 live births in the Northern Solomons, to above 100 per 1,000 in the Southern Highlands province. Acute respiratory infections (ARI) are the most common causes of death among both young and old. According to health statistics, over 60 per cent of those dying from pneumonia in 1989 were children under one year of age. Malaria and diarrhoeal diseases are, respectively, the second and third most common cause of death among children under five years of age.

4. Women aged 15 to 44 years make up 20 per cent of the total population. With regard to women's health, the priority areas of concern relate to the high levels of maternal mortality, malnutrition, malaria, sexually transmitted diseases (STDs) and acquired immune deficiency syndrome (AIDS). The maternal mortality rate (MMR) remains high, at 800 per 100,000 live births, with variations from 200 per 100,000 live births in urban areas to 1,200 per 100,000 live births in the remote areas, particularly in the highlands. The actual figure may be much higher, since only about 10 per cent of deliveries are reported through health and hospital centres, and only about 40 per cent of women undergo supervised deliveries. Poor access to maternal health care, malnutrition and infectious diseases, such as malaria and pneumonia, are the

main contributors to maternal death. As of 1990, 40 per cent of the diagnosed cases of AIDS were in women, and there is good evidence to fear that AIDS will become widespread, following a similar pattern as STDs.

5. Breast-feeding is almost universal and is prolonged in many parts of the country, particularly among highland women, but complementary foods are not introduced early enough, and malnutrition sets in at the start of the weaning period. It was estimated that, in 1990, some 35 per cent of the children under five years of age were underweight, and the percentage may be much higher in areas such as the Eastern Highlands, Morobe and Milne Bay provinces and parts of the Sepik province. Apart from protein-energy malnutrition, which is a common problem for both women and children, there are also other forms of malnutrition, such as anaemia, obesity, endemic goitre and cretinism and vitamin A deficiency, but their extent cannot be fully assessed owing to incomplete data.

6. Inadequate water supply and poor sanitation remain a serious problem. Only approximately 23 per cent of the rural population have access to safe water, and 20 per cent have proper sanitation facilities. Poor water supply and sanitation conditions are contributing factors to the high incidence of diarrhoeal and other diseases.

7. The primary school enrolment rate increased from 59 per cent in 1980 to 73 per cent in 1989, but the number of children not attending school is still quite considerable. Gender differentials can be noted in the primary school enrolment ratio: for females, the ratio was 67 per cent in 1989, compared with 79 per cent for males. High drop-out rates remain a major problem. For the period 1984-1989, more than one third of grade 1 children dropped out before completing grade 6. Delayed entrance of school-age children into grade 1, the shock of suddenly having to learn in a foreign language, an irrelevant curriculum and lack of educational materials have been perceived to be contributing factors to the drop-out problem. The average adult literacy rate is 51 per cent, with the female literacy rate at only 38 per cent. A national literacy and awareness programme was launched by the Government in 1988 and, along with it, a National Literacy Council was created, composed of both government institutions and non-governmental organizations (NGOs). However, the non-formal education programmes are often constrained, owing to lack of commitment in some provinces. The difficulty of attracting and maintaining qualified personnel and the low level of public awareness also confound local-level implementation of activities.

8. There is an overall lack of recognition of women's contributions to development, and women's concerns and issues are by and large neglected. Negative traditional and public attitudes towards women's participation in development pose a serious barrier to the improvement of women's status. Women have limited access to information and agricultural extension. Women's organizations are weak and receive little direction or support, although a nationwide network exists. Legal protection for women's rights is weak, and incidences of wife-beating, rape and other forms of violence against women are widespread.

PROGRAMME COOPERATION, 1988-1992

9. The first period of programme cooperation aimed at improving the quality of life of children and women in Papua New Guinea by supporting the national objectives of reducing infant, child and maternal mortality rates. The national expanded programme on immunization (EPI) and the control of diarrhoeal diseases (CDD) programme were selected as main programme thrusts, along with social mobilization and advocacy and an area-based programme to demonstrate community-based approaches in child survival and development (CSD).

Health

10. EPI coverage increased markedly, although the target of universal child immunization (UCI) has not yet been achieved, largely owing to the country's budget cutbacks for all rural health services, beginning in mid-1990 because of the closure of Bougainville copper mine. From 1987 to 1990, coverage with antigens increased from 74 to 89 per cent for tuberculosis, from 44 to 69 per cent each for combined diphtheria/pertussis/tetanus and poliomyelitis, from 37 to 67 per cent for measles and from 24 to 70 per cent of pregnant women with tetanus toxoid. Training was a priority activity throughout programme implementation, along with extensive support in the form of the provision of cold-chain and vaccination equipment. Some 400 mid-level managers at provincial and district levels received training in planning, management and social mobilization, and 120 aid-post orderlies were trained to support immunization activities.

11. The promotion and use of oral rehydration salts (ORS) as part of oral rehydration therapy (ORT) formed a main component in the CDD programme. Assistance was provided to provinces to help them to develop provincial CDD action plans. About 1 million ORS packets were supplied and distributed and training was provided for 400 CDD managers at all levels. A simple instruction card for the preparation and use of ORS was developed and distributed widely to mothers through maternal and child health (MCH) clinics, churches and women's groups. In collaboration with the World Health Organization (WHO), support was provided for the production of CDD training materials for community health workers (CHWs).

12. To address the high MMR, the programme began supporting the training of village birth attendants in Losuia, Southern Highlands and Milne Bay provinces. By the end of 1991, 60 village birth attendants had been trained, and work on curricula standardization had been initiated. Family planning has been supported through health education. Approximately 130 communicators and 200 health personnel were trained in family planning.

Women in development

13. Assistance has been provided at the national level to the Women and Law Committee, in support of the national campaign against domestic violence. In collaboration with Canadian University Services Overseas, support was provided to the National Institute of Medical Research for the publication of a

monograph on the health of women, and following that, a high-level strategy meeting was held to discuss the identified problems. In support of the World AIDS Day, a women and AIDS awareness workshop for 37 women leaders and health workers was hosted by the Departments of Health and Home Affairs and Youth, with assistance from WHO and UNICEF.

Area-based child survival and development

14. The mid-term review of the country programme in late 1990 indicated satisfactory achievements in the area-based CSD programme in the Southern Highlands province. Although beset by problems similar to those experienced in the national programmes - tribal fights, the budget cutbacks and quick turnover of government personnel - the CSD programme in the Southern Highlands province seemed to have achieved better results. By 1991, UCI was achieved province-wide, with above 80 per cent coverage for all four antigens. Training was carried out in EPI and CDD programmes for mid-level managers, nurses, aid-post orderlies and CHWs for improvement of their skills in supervision, social mobilization and CDD case management. A pilot project on birth registration, which involved record-keeping on every newborn baby, showed positive results in improving MCH follow-up action. Model ventilated smoke-free houses were constructed for demonstration purposes in strategic areas to promote the reduction of ARI. Permethrine-impregnated mosquito nets were provided to highly malaria-endemic areas.

15. The programme also made progress in nutrition-oriented activities. The family food production and nutrition project moved from demonstration areas to households. Cooking demonstrations were held at the village level to improve family nutrition. Fish production was introduced, and about 38 fish ponds are now regularly producing and being harvested for family and community consumption. Support was provided to the Division of Primary Industry, which delivered technical assistance and supplied materials, including fingerlings and animals such as poultry, sheep and goats, for the promotion of the household husbandry industry. The integration of women in development in the community-based programme has been initiated. Training workshops were conducted in the last quarter of 1991 to create awareness of gender issues among politicians, policy makers and government officials, most of whom are men.

16. While the achievements in the Southern Highlands province were encouraging, progress in the Kila-kila urban settlement project was disappointing. The project aimed to establish an integrated multisectoral system, where health, education and other basic services could be improved through community participation. But little progress was made in community participation or the integration of services owing to the rigidity of the existing structure for urban development. Since a change in government policy will discourage the establishment of urban squatter settlements, the project for urban basic services will have to be redesigned in the new country programme.

Social mobilization

17. UCI has been a rallying point for advocacy and social mobilization. Advocacy for political commitment to social development, focusing on children and women, received a major boost with the Prime Minister's participation in the World Summit for Children and his signing of both the Summit Declaration and Plan of Action, and the Convention on the Rights of the Child. At the same time, a study on "adjustment with a human face" was completed, and the situation of children and women was updated to prepare the new country programme of cooperation and the national programme of action for children, a major follow-up to the World Summit. The media has been used to enhance public awareness of issues affecting children and women, such as adjustment policies, women's health, literacy programmes and domestic violence.

18. At the programme level, the adaptation of Facts for Life has been completed and is now being used as a tool for awareness-raising. Knowledge, attitude and practice studies and media surveys provided the basis for designing the messages. Some 30 media people were sensitized through workshops, and 80 communicators were trained in community theatre and communication through puppetry.

RECOMMENDED PROGRAMME COOPERATION, 1993-1997

Recommended general resources: $5,260,000
Supplementary funding: $5,000,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health	1 200	1 500	2 700
Education	910	1 750	2 660
Women in development	450	750	1 200
Area-based programme	1 000	1 000	2 000
Social mobilization	450	-	450
Planning, monitoring and evaluation	450	-	450
Programme support	800	-	800
Total	5 260	5 000	10 260

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

Programme preparation process

19. Preparation for the new country programme commenced with the November 1990 mid-term review, which was undertaken jointly by the Government and UNICEF. The first draft of the situation analysis, programme objectives and strategies were presented and discussed in the programme strategy meeting held in April 1991, with the active participation of the Government, NGOs, United Nations and other international agencies and bilateral donor countries. A preview meeting followed in July, at which programme plans of operations were reviewed. Since programme preparation began immediately after the World Summit for Children, the focus of the entire exercise was on follow-up of the 1990s goals.

Programme objectives

20. The new programme of cooperation seeks to advance the following national goals and objectives, which are also in line with the goals set out by the World Summit for Children: (a) to reduce IMR from 56 per 1,000 live births in 1990 to 40 by 1997; (b) to reduce MMR from 800 per 100,000 live births in 1989 to 400 by 1997; (c) to improve the nutritional status of children and women; (d) to improve access to basic education and raise the literacy rate for females from 38 per cent in 1990 to 60 per cent by 1997; and (e) to improve women's status and strengthen their participation as both active implementors and beneficiaries in the development process. These goals are reflected in sectoral development plans, including the National Health Plan, 1991-1995, and the National Women's Policy, and will be incorporated into the national programme of action for children and the National Development Plan, 1994-1998.

Programme strategy

21. Based on the situation analysis of children and women and the findings of the mid-term review of the previous country programme, the following major strategies will be continued and further strengthened to provide support for achievement of the national goals: (a) activities directly related to CSD will be emphasized; (b) vulnerable and inaccessible groups will be reached through the area-based CSD programme; (c) community involvement will be promoted through awareness-raising and the reduction of gender disparities; (d) integration and convergence of services will be strengthened for increased effectiveness; and (e) government capacities in planning, monitoring and coordination of services for children and women will be enhanced.

Health

22. EPI will continue to be a major component of the health programme to help the country achieve its UCI goal by 1992 and to reach 90 per cent coverage for tetanus toxoid by 1997. The EPI project will focus on strengthening the maintenance of the cold chain and enhancing capacities in service delivery, management, supervision, monitoring and evaluation. Support will also be provided for the development and production of information materials and

education and communication activities, as well as for networking with other sectors, such as the media, for social mobilization.

23. CDD, ARI and malaria control activities will be implemented through a package of primary health care services. The focus of CDD activities will be on the promotion of ORT to increase its accessibility and use, along with interventions in the areas of breast-feeding, safe weaning food practices and personal and domestic hygiene. Efforts to control ARI will stress standardization of diagnoses, case management and training. Permethrine-treated mosquito nets will continue to be supplied to control malaria. By 1997, at least one health worker in each health facility will receive training in the correct diagnosis and treatment of diarrhoea, pneumonia and malaria. AIDS education activities will be incorporated into community school curricula, and training in this area will be provided for teachers in over 60 per cent of schools.

24. Safe motherhood will be strengthened in view of the current high MMR. Activities in MCH will be strengthened through community-based approaches and enhancement of the capacities of health centres, subcentres and aid-posts for improved antenatal care, screening and referral of women with high-risk pregnancies. The training of village birth attendants will continue to be supported with a target of reaching 1,500 of them by 1997. Maternal nutrition will also be stressed, not only for pregnant women, but for the girl child as well. Nutrition education will be included in community school curricula, and the promotion of breast-feeding, growth monitoring and nutrition surveillance will be supported.

Education

25. In collaboration with the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Development Programme (UNDP), the Asian Development Bank and other external agencies involved in education, support will be provided to assist the Government in the preparation of the National Decade Plan for Education for All. The programme will focus on the following objectives: providing educational opportunities for the most disadvantaged groups of children and youth; improving the literacy rate among girls and women; providing opportunities for early childhood development (ECD); and improving school retention rates and curriculum relevance, especially for the benefit of disadvantaged children and women.

26. Community schools will be assisted as alternative primary education delivery systems for remote areas. Pilot testing of community-based approaches will be carried out, involving alternative ways to implement curricula and community cost-sharing. To support the government goal of increasing the female literacy rate to 60 per cent by 1997, training will be provided for 2,000 literacy teachers, and a literacy and awareness information system focusing on women's concerns will be established, linked to 600 village production centres for literacy materials. An ECD component will also be supported. The aim will be to benefit 250,000 young children through

advocacy, developing modules for educational materials and training 420 pre-school teachers and child-care workers. Pilot activities to improve learning achievement and curriculum relevance will be carried out in five selected provinces with low enrolment and school retention rates. Some 100 trainers and curriculum writers and 2,500 teachers will receive training.

Women in development

27. The programme seeks to strengthen the capacity of relevant government departments to integrate gender and women's concerns into the mainstream of policies, plans and programmes. Support will be provided for research, training, preparation of training materials and skills training for gender-sensitive planning and programming. A database disaggregated for gender will be established, and training activities will reach 150 national and provincial government officials and trainers and 282 women's organizations. Advocacy and social mobilization will also be supported. Main activities will include the production of briefing kits on gender to sensitize politicians, court magistrates and the police on these issues, and the preparation of a women's legal-rights resource book and a national campaign against domestic violence.

Area-based child survival and development

28. This programme will be implemented in the Southern Highlands and Milne Bay provinces, aiming at the reduction of high infant, child and maternal mortality rates and high-level malnutrition. An integrated community-based approach will be continued, involving acceleration of EPI, CDD, control of ARI and malaria, training of village birth attendants, growth monitoring and promotion, water supply and sanitation, family food production and nutrition and increased involvement of women. The programme is designed to link with national programmes for mutual reinforcement. Assistance will focus on strengthening capacities of the two provinces in the areas of baseline surveys, planning, programming, coordinating programme implementation, monitoring and evaluation. It is planned to extend services to the entire province of Southern Highlands, which has an estimated total population of 303,000, and three districts of Milne Bay, covering about 100,000 children and women.

Social mobilization

29. The programme aims to achieve the following objectives: (a) to generate and strengthen political will, legislative action and policy, programme and budget decisions in favour of children and women; (b) to expand partnerships and alliances with various sectors, particularly NGOs, women's organizations and media groups; (c) to integrate advocacy and social mobilization into all programmes; (d) to strengthen capacity for planning and implementing information, education and communications programmes; and (e) to improve national, provincial, district, community and women's awareness of issues and concerns affecting children and women.

30. Support will be provided for follow-up to the World Summit for Children, the Convention on the Rights of the Child and the Jomtien Declaration on Education for All. The programme will assist the Government to review and analyse existing legislation, policies and national declarations of intent for children and women to identify gaps and make necessary recommendations. Advocacy tools and materials in the form of brochures, leaflets, slide sets and videos will be prepared, directed towards the national and provincial leadership, legislators and senior public servants. An information resource unit will be established, which will include the gender-sensitive database mentioned earlier. Training will be provided to upgrade programme implementors' knowledge, skills and practices in social mobilization, with a priority focus on women through women's groups.

Planning, monitoring and evaluation

31. The programme will continue to assist the Government in analysing the situation of children and women and preparing and updating the national programme of action for children. In collaboration with other United Nations and external agencies, a comprehensive planning and monitoring system will be established, geared towards improving services for children and women. Support will be provided to strengthen the capacities of government departments at various levels, in particular, coordinating agencies such as the Department of Finance and Planning and the National Government's Quality of Life Committee. The focus of this support will be on data collection and analysis, disaggregating data for gender and policy-making. Planning and monitoring activities related to specific goals have also been incorporated into sectoral programmes. Field visits to project areas will be made jointly by the Government and UNICEF, and, where necessary, involve other collaborating external agencies or bilateral donors. Programme reviews and evaluations and annual reviews will be held, and a mid-term review will be conducted during the third year of the country programme, when both achievements and constraints will be analysed and major course corrections, if any, will be decided.

Programme support and management

32. The programme of cooperation will be coordinated by the Department of Finance and Planning, together with the relevant departments comprising the Inter-Agency Committee for Child and Women Survival and Development, under the National Government Quality of Life Committee. The UNICEF Area Office at Manila and the sub-office at Port Moresby will assist the Government of Papua New Guinea in the planning, implementation, monitoring and evaluation of the programmes.

33. Collaboration with other international agencies, such as WHO, the United Nations Population Fund (UNFPA), UNDP and the United Nations Environment Programme (UNEP), and bilateral and national agencies will be pursued to ensure complementarity of inputs and to help maximize impact on the beneficiaries.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Papua New Guinea (1990 and earlier years) UNICEF country classification

Under-five mortality rate	80	(1990)	High U5MR
Infant mortality rate	56	(1990)	High IMR
GNP per capita	$ 860	(1990)	Lower-middle GNP
Total population	3875.0 Thousands	(1990)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1990
Births	(thousands)	100	116	118	131
Infant deaths (under 1)	(thousands)	12	9	8	7
Under-five deaths	(thousands)	17	13	11	11
Under-five mortality rate (per 1,000 live births)		166	112	93	80
Infant mortality rate (under 1) (per 1,000 live births)		118	80	67	56

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1980/1984)	Moderate & severe	..	35
	Severe	..	..
Babies with low birth weight (%, 1979)		25	..
% of primary school children reaching final grade (1980/1988)		66*	62

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1980/1985)		../../..	../../..
Prevalence of wasting (%, 1980/1985)		52	..
Prevalence of stunting (%, 1980/1985)		..	..
Daily per capita calorie supply (% of requirements, 1979-1981/1988)		95	98
Food production per capita index (Index 1979-1981=100, 1980/1990)		99	105
Household expenditure (% of total income, 1980-1985)	All food/cereals		../..

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1989)			46
Access to health services (% of population)	Total	..	..
	Urban/rural	../..	../..
Access to safe water (% of population, 1980/1988)	Total	16	34
	Urban/rural	55/ 10	93/ 23
Access to adequate sanitation (% of population, 1980/1985)	Total	17	45
	Urban/rural	96/ 3	99/ 35
Births attended by trained personnel (%, 1989)		..	20
Maternal mortality rate (per 100,000 live births, 1980)		900	..

Immunization		1981	1985	1990
One-year-olds (%) immunized against:	Tuberculosis	64	66	89
	DPT	50	36	69
	Polio	32	31	69
	Measles	..	25	67
Pregnant women (%) immunized against	Tetanus	..	..	70

/...

TABLE 1 (continued)

Papua New Guinea

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	59/ ..	73/ 73
(%, 1980/1989)	Male	66/ ..	79/ 78
	Female	51/ ..	67/ 67
Secondary enrolment ratio (gross/net)	Total	12/ ..	13/ ..
(%, 1980/1988)	Male	15/ ..	16/ ..
	Female	8/ ..	10/ ..
Adult literacy rate, 15 years & older	Total	32	52
(%, 1970/1990)	Male/female	39/ 24	65/ 38
Radio/television sets			
(per 1,000 population, 1980/1988)		58/ 0	64/ 2

DEMOGRAPHIC INDICATORS		1970	1980	1985	1990	2000**
Total population	(Thousands)	2422.0	3086.0	3460.0	3875.0	4845.0
Population aged 0-15 years	(Thousands)	..	1394.7	1527.6	1659.6	2001.2
Population aged 0-4 years	(Thousands)	..	484.5	540.8	589.3	691.6
Urban population (% of total)		10	13	14	16	20
Life expectancy at birth	Total	46	51	53	55	59
(years)	Male	47	50	52	54	58
	Female	46	51	54	56	60
Total fertility rate		6.1	5.7	5.4	5.0	4.0
Crude birth rate (per 1,000 population)		42	38	35	34	30
Crude death rate (per 1,000 population)		18	14	12	11	9

		About 1980	Most recent
Contraceptive prevalence rate		..	4
(%, 1986)			
Population annual growth rate	Total	2.3	2.3
(%, 1965-1980/1980-1990)	Urban	8.4	4.2

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate		0.0	-0.5
(%, 1965-1980/1980-1990)			
Inflation rate (%, 1965-1980/1980-1989)		8	6
Population in absolute poverty	Urban/rural	10/ 75	../ ..
(%, 1979)			
Household income share	Top 20%/bottom 40%	../ ..	../ ..
(%)			
Government expenditure	Health/education	9/ 17	9/ 15
(% of total expenditure, 1980/1988)	Defence	4	4
Household expenditure	Health/education		../..
(% of total income, 1980-1985)			
Official development assistance:	US$ millions	326	334
(1980/1989)	As % of GNP	14	10
Debt service			
(% of goods & services exports, 1980/1989)		6	16

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1988-1992 a/

(In thousands of United States dollars)

COUNTRY: PAPUA NEW GUINEA
LATEST BOARD APPROVAL: 1988
GENERAL RESOURCES: $2,540,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Total
Health	479	174	81	39	48	32	653	230	1261	475	1736
Water supply and sanitation	1	55						12	1	67	68
Nutrition	23		17		17		40		97		97
Education			18						18		18
Community organization and development	4		2				38		44		44
Women-centred programme			7				5		12		12
Advocacy	48		3				103		154		154
Planning and project support	108		7		195		217		527		527
Freight	24	13							24	13	37
GRAND TOTAL	687	242	135	39	260	32	1056	242	2138	555	2693

GR = General resources.
FSF = Funded supplementary funding.
a/ The current programme cycle covers period 1988-1992, but actual expenditure figures are only available through 1991.

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TABLE 3. PLANNED EXPENDITURE, 1993-1997

(In thousands of United States dollars)

Country: PAPUA NEW GUINEA Period covered: 1993-1997	Funding status	1993	1994	1995	1996	1997	Total
Health	GR	320	220	220	220	220	1200
	NSF	300	300	300	300	300	1500
Education	GR	230	170	170	170	170	910
	NSF	350	350	350	350	350	1750
Women in development	GR	90	90	90	90	90	450
	NSF	150	150	150	150	150	750
Area-based programme	GR	280	180	180	180	180	1000
	NSF	200	200	200	200	200	1000
Social mobilization	GR	90	90	90	90	90	450
Planning and social statistics	GR	90	90	90	90	90	450
Programme support	GR	160	160	160	160	160	800
TOTAL	GR	1260	1000	1000	1000	1000	5260
	NSF	1000	1000	1000	1000	1000	5000
GRAND TOTAL		2260	2000	2000	2000	2000	10260

GR = General resources.
NSF = New supplementary funding.

TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: PAPUA NEW GUINEA	Number of posts	Amount (Thousands of United States dollars)
FINANCED FROM 1992-1993 APPROVED BUDGET:		
International Professional established posts	1	278
Local national Professional and General Service established posts	3	129
Operating costs		275
Total	4	682
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources	3	654
Supplementary funds	0	0
Local national Professional and General Service project posts		
General resources	2	43
Supplementary funds	1	42
Total	6	739

a/ For information source, see the 1992 revised post authorization table, dated 23 July 1991.

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FOR ACTION

RELIEF AND REHABILITATION PROGRAMME*

Afghanistan

The Executive Director recommends that the Executive Board approve the relief and rehabilitation programme for Afghanistan for the period 1992-1994 in the amount of $16.5 million from general resources, subject to the availability of funds, and $20.9 million in supplementary funds, subject to the availability of specific-purpose contributions.

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* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1991, will be contained in the "Summary of 1992 recommendations for general resources and supplementary funding programmes" (E/ICEF/1992/P/L.2 and Add.1).

THE SITUATION OF CHILDREN AND WOMEN

1. During the second half of 1991, there was some progress towards a negotiated peace settlement in Afghanistan. The Secretary-General's five-point plan was agreed upon by the Kabul Government and moderate mujahidin groups. The agreement between the United States of America and the former Union of Soviet Socialist Republics concerning the cut-off of arms supplies became effective on 1 Janaury 1992. Representatives of the Governments of Pakistan and the Islamic Republic of Iran and of the mujahidin met to discuss a peaceful settlement. A mujahidin delegation also visited Moscow, resulting in the withdrawal by the former Soviet Union of military advisers from Kabul and the release of Soviet prisoners of war.

2. Unfortunately, even if an agreement is reached between the moderate mujahidin parties and the Kabul Government, a total cease-fire is still far off. More than 1,000 commanders, who have been heavily supported throughout the war with food and funds, will be left out of any new government arrangements and will continue to fight for their power base. Many are benefiting from the sale of opium, which will continue to provide them with the necessary economic support. Therefore, although the scope and level of hostilities are likely to decrease over the next few years, pockets of fighting will remain and families will suffer.

3. Even before the Soviet invasion, Afghanistan was one of the poorest, least developed countries in the world. Thirteen years of war have destroyed the country's physical infrastructure and social fabric and turned one third of the population into refugees. More than 1 million people have died, tens of thousands have been wounded and between 300,000 and 500,000 permanently disabled. There are now an estimated 500,000 to 700,000 widows and orphans.

4. The winter of 1990-1991 was exceptionally hard. As a result of difficult trading conditions and the poor 1990 harvest, food and other commodities were expensive and in short supply. A strong earthquake in the north-east of the country in February and widespread flooding in the south-west created more difficulties for many families. In the spring, the resumption of active military operations sustained the rapid rate of inflation and reduced even further the real value of limited government resources spent on social and development activities, already low because of the high priority accorded to the military.

5. Afghanistan's precarious economic situation is reflected in its social indicators. The infant mortality rate is estimated at 169 per 1,000 live births and the under-five mortality rate at 296 per 1,000 live births. Diarrhoeal diseases, acute respiratory infections (ARI), measles and other vaccine-preventable diseases, together with malnutrition, account for more than 50 per cent of those deaths. The maternal mortality rate was estimated at 690 per 100,000 live births in 1980 and may have increased since. This was primarily because of the lack of prenatal care, untrained birth attendants and unsanitary delivery conditions.

6. According to an assessment of the health sector by the World Health Organization (WHO), in 1990 there were only 82 health centres and 17 sub-centres operating in the country, compared with 147 and 76, respectively, in 1979. They serve barely 17 per cent of the rural population. It is estimated that 39 per cent of the urban and only 17 per cent of the rural population have access to safe drinking water. Environmental sanitation is almost non-existent in rural Afghanistan.

7. In the area of education, the situation is equally distressing. Afghanistan's adult literacy rate of about 29 per cent (14 per cent for women) is one of the lowest in the world; rural women are almost totally illiterate. Thirteen years of war have destroyed the educational infrastructure and disrupted education services. Some 2,000 teachers have been killed and thousands dislocated, while more than 10,000 are under arms. Only 33 per cent of boys and 17 per cent of girls are estimated to be enrolled in primary school, mostly in urban areas.

8. More than a decade of civil strife and social disruption has adversely affected the situation of women. Many have been widowed or have suffered serious disabilities. Despite the fact that women make up more than a half of the country's human resource potential, to date, little investment has been made in programmes to build and harness women's abilities to benefit themselves, their families and communities or national development.

9. In Afghanistan, disability and trauma will be for years to come permanent and costly reminders of the conflict. The most visible disabilities are caused by amputation and poliomyelitis. Less noticeable, but present in increasing numbers, are the visually- and hearing-impaired and the mentally retarded. The problem of war-related mental illness and psychological trauma appears to be greater than previously recognized and cannot be treated adequately by existing services.

PROGRAMME COOPERATION, 1990-1991

10. Major programme emphasis during 1990-1991 was on emergency intervention and child survival activities, especially immunization. However, cooperation in water supply and sanitation was also expanded and new activities were developed for women with special needs and children in especially difficult circumstances. Because of a lack of government personnel and trained counterparts in general, UNICEF strengthened its presence in Afghanistan, increasing the number of Professional staff from 3 to 18. For the first time, staff were able to travel outside the major cities and to establish contacts with local leaders and rural communities.

Health

11. The expanded programme on immunization (EPI) focused on improving coverage in urban and peri-urban areas. UNICEF helped to resupply vaccines and to maintain the cold chain at 116 fixed EPI units operated by the Ministry of Public Health, 12 of which were newly established, and at 14 fixed centres established by communities in mujahidin areas. A large-scale training/retraining programme was initiated for the estimated 1,000 EPI personnel, reaching 300 by the end of 1991, while 400 community and religious leaders were oriented in order to increase community involvement. Monitoring activities were intensified and steps were taken to improve the reporting and data-processing systems.

12. Efforts were made to restructure the rural programme, which is implemented by eight non-governmental organizations (NGOs) in order to conform to WHO/UNICEF guidelines. The target age for children was reduced from five to two years, with emphasis on reaching children under the age of one year as much as possible, while the vaccine regimen was also modified. The central cold store in Peshawar was improved further through the installation of 10 additional ice pack freezers, and seven vaccine storage facilities were established in strategic rural locations, thus reducing the time vaccinators spend travelling to Peshawar to resupply.

13. During 1990, more than 208,000 children under one year of age in urban areas received three doses of combined diphtheria/pertussis/tetanus vaccine, while 169,000 received one dose of measles vaccine, which exceeded the target set. In the rural programme, some 120,000 children under five years of age (25 per cent of the target) were fully immunized, as were 89,000 women between the ages of 15 and 45 years old (30 per cent of the target). Taking into account the increased focus on children under one year of age during 1991, complete immunization of this age-group is expected to reach 30 per cent nationwide by the end of 1992. Tetanus toxoid coverage of women of child-bearing age continues to be low, at 4 per cent nationally; only half of the targeted women between the ages of 14 and 45 years (166,753) received two doses.

14. Regarding the control of diarrhoeal diseases (CDD), increased emphasis was placed on improving knowledge of diarrhoea management and oral rehydration therapy (ORT) and on raising the demand for oral rehydration salts (ORS). Some 50 ORT corners were set up in Kabul and another 50 in seven other urban centres. Those corners are each staffed by two health workers whose training and orientation in CDD were supported by UNICEF. The clinical programme was supported by a continuing mass media campaign focusing on home management of dehydration, proper feeding during diarrhoea episodes and related health matters. The production of ORS reached 1.75 million packets in 1991 (the estimated annual requirement is 3 million packets), which are distributed from 375 health institutions and schools in Kabul and in both government and mujahidin-controlled areas in 20 provinces.

15. The maternal and child health (MCH) project assisted minor renovations of 50 health centres in areas controlled by the Government and 14 in mujahidin-controlled areas, and also distributed essential drugs, health supplies and equipment in 21 provinces. Micronutrient supplements to combat anaemia, vitamin A deficiency and iodine deficiency disorders were distributed through 140 health centres in both government and mujahidin areas. Primary health care (PHC) training, with particular emphasis on MCH, was provided to 175 health staff, 110 traditional birth attendants (TBAs) and 53 community health volunteers. Discussions have begun with WHO and the United Nations Population Fund (UNFPA), which are currently trying to renew an emphasis on family planning and child spacing in the country, on integrating the promotion of safe motherhood into those efforts. During 1991, community leaders were identified by UNICEF field staff and contacted individually to facilitate communications with mothers in their communities. The great majority were responsive and helped to increase the access to those previously unreached by MCH services.

16. A programme to control ARI was initiated during 1991, in consultation with WHO. Treatment guidelines were disseminated during the training of 115 medical and paramedical staff at Kabul. Treatment charts and related educational materials highlighting advice on home care, referral and the rational use of antibiotics were prepared and distributed, while supplies of appropriate drugs and equipment were procured and delivered. A part-time national project manager for ARI control was appointed by the Government in the Ministry of Health.

Water supply and sanitation

17. For the first time since 1979, water supply and sanitation activities were expanded outside Kabul to the provinces of Herat, Balkh and Baghlan in 1990. In 1991, activities were carried out in nine provinces, focusing primarily on providing or reactivating water points in schools, hospitals, mosques and children's institutions, as well as rehabilitating village water supply systems. Because of the grave shortage of skilled technicians, UNICEF supported short courses in the rehabilitation and development of water supply and sanitation systems and the development of ground-water and drilling techniques for 150 participants from eight provinces. In addition, sanitation campaigns were implemented in the cities and surrounding areas of Kabul, Mazar, Herat and Faizabad. The World Food Programme (WFP) assisted the campaigns by providing food for work. In Mazar, UNICEF provided shovels and lime and hired horse-drawn carts to remove garbage. With the support of the community, refuse was collected, deposited in a designated site and covered with lime, preventing an annual outbreak of cholera.

Nutrition

18. In order to raise awareness of how better nutrition practices can improve child growth and development, a nutrition module was included in all sectoral training supported by UNICEF, and appropriate communication materials were

circulated and broadcast on radio and television. Because declining breast-feeding in urban areas has become a concern, the Kabul Government has developed legislation to promote breast-feeding instead of breast milk substitutes. A few mullahs already support breast-feeding through their sermons in the mosques; that and other avenues to raise public awareness are being pursued.

Education

19. In 1991, the recommendations of the World Conference on Education for All were reviewed by the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Development Programme (UNDP) and UNICEF, resulting in the launching of a national seminar that was attended by 127 education directors, teachers and community leaders. During 1990, UNICEF assistance included the procurement of basic school supplies for 400,000 primary school children and classroom supplies for more than 50 schools. Three-week "crash" training courses were organized for 500 untrained teachers, mostly women, in Kabul, Mazar, Herat and Nangarhar. UNICEF also provided basic pupil and classroom supplies to 70 selected school centres, set up and maintained by the community and serving about 70,000 primary-age children in four provinces. Some 40 per cent of the assistance went to mujahidin areas.

Women with special needs

20. In collaboration with the Afghan Women's Council, 500 women were trained in various aspects of mobilization and leadership. Pilot income-generation and skills training projects were initiated for 587 needy women in Kabul and Mazar. Some 800 literacy classes are operating in government-controlled areas of 11 provinces, reaching a total of 24,000 women. A database is being established that will utilize the Council's network. According to early unverified indications, 21 per cent of the women in Kabul are widows and 13 per cent have some kind of impairment.

Children in especially difficult circumstances

21. Finding the right partners for carrying out activities for children in especially difficult circumstances has been difficult. However, given the great need in this area, UNICEF has supported a number of NGO initiatives on a pilot basis. In 1990, UNICEF provided assistance to a home for abandoned children and children whose parents are imprisoned, which was established by the Norwegian Red Cross. In collaboration with the International Assistance Mission, special burn packs were developed and distributed to children burned by flares falling on Kabul. During 1991, the International Committee of the Red Cross (ICRC) agreed to collaborate with UNICEF in extending prosthesis and orthopaedic services to more children and women. A consultant is being provided by UNICEF to design and implement rehabilitation programmes for those disabled children. In addition, some 311 disabled or impaired children identified by a project of the International Labour Organisation (ILO) are being assisted by UNICEF through the Afghan Red Crescent Society (ARCS).

Winter emergency programme

22. From January to May 1990, 90,000 children under five years of age were screened in Kabul, Mazar and Herat and 25,000 identified as moderately malnourished received supplementary food. Three hospitals catering to children were rehabilitated and served as referral centres for the severely malnourished. In addition, 30,000 children's blankets, 40,000 adult blankets and 50,000 bars of soap were distributed to needy families, while 360 emergency medical and supplementary drug kits were made available to health institutions.

23. The United Nations Office of Coordination for Afghanistan (UNOCA) launched another winter emergency appeal for 1991. In response, UNICEF carried out an extensive emergency programme that focused on nutrition screening and the distribution of supplementary food and micronutrient supplements. Those activities increased the access of UNICEF to a great number of communities in both urban and rural areas. Consequently, UNICEF regular programmes such as EPI and nutrition have been developed further and extended to those communities. Between December 1990 and May 1991, the programme was carried out in 13 provinces, benefiting 285,000 children, of whom 45 per cent were in mujahidin-controlled areas.

Emergency preparedness

24. Programme bases were established in Mazar and Herat, in addition to those in Kabul and Peshawar, in order to increase service delivery to as many rural and urban areas as possible. Assessment and various programme delivery-related missions were carried out in 20 of the 30 provinces. Staff were also stationed for shorter periods in Faizabad, Zaranj, Lashkargah and Bamyan during an earthquake and flood disaster relief operation mounted by the United Nations in the first half of 1991. That enabled the distribution of essential drugs and micronutrient supplements and provided vital information on the political situation and the possibility of establishing services for vulnerable groups. Contacts made with shuras (local councils) have paved the way for advocacy for child survival and increased demand for child-saving interventions. Five warehouses with a capacity of 5,000 tons were maintained in four provinces.

Assistance to refugees

25. In the refugee camps located in three provinces of Pakistan, UNICEF continued to assist immunization and CDD activities carried out by the Office of the United Nations High Commissioner for Refugees (UNHCR), in cooperation with the Government of Pakistan. In two provinces, 80 per cent of children under two years of age and 60 per cent of women of child-bearing age have been fully immunized; in the third, only 57 per cent of each group have been immunized. A comprehensive CDD programme was formulated, focusing on training health workers in correct case management and increasing the knowledge of caretakers about diarrhoea management and prevention. Some 250,000 ORS packets were distributed, while pregnant women received iron, folic acid and vitamin A supplementation. In collaboration with NGOs, a series of

silk-screened posters, flipcharts and booklets with simple health messages was developed, printed and distributed; TBAs, female health workers and supervisors were trained; and a pictorial handbook for female health workers was produced.

RECOMMENDED PROGRAMME COOPERATION, 1992-1994

Recommended general resources: $16,500,000
Supplementary funding: $20,900,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health	7 250	8 760	16 010
Water supply and sanitation	1 500	6 260	7 760
Nutrition	750	480	1 230
Education	1 350	1 750	3 100
Women-centred programme	750	1 200	1 950
Children in especially difficult circumstances	750	1 250	2 000
Emergency preparedness	1 500	1 200	2 700
Programme support	2 650	-	2 650
Total	16 500	20 900	37 400

a/ A breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

26. Despite the many efforts to arrange a peaceful solution to the conflict in Afghanistan, fighting may continue for some time. Therefore, the 1992-1994 programme will continue to have an emergency orientation, but rehabilitation will also be stressed and activities will be planned with a view to laying the groundwork for a future development programme. The objectives are to promote child survival, meet emergency relief needs, assist children and women in especially difficult circumstances and support the rehabilitation of essential services.

Programme strategy

27. Afghan women and children most in need will remain the focus of UNICEF-assisted interventions. Programme activities will be designed to respond and adjust to the changing realities of the country. Despite continuing hostilities, experience has shown that by working with a number of different partners, it is possible to extend services beyond the major cities to other provincial and district capitals, as well as to a growing number of rural areas.

28. The implementation strategy will be to work through all possible channels, especially with community leaders in both urban and rural areas, either directly or through NGOs. The office structure, security permitting, will include staff outposted to five key locations in order to facilitate local contacts. Because of the shortage of trained counterparts, it will be a more "hands-on" operation than is normal for UNICEF and, therefore, staff intensive. In addition to reinforcing staff capacity, it is planned to employ United Nations Volunteers. Emphasis will be placed on empowering the community to solve its own problems and manage community services since no central Government will be able to meet social needs in the foreseeable future.

29. Given that urban areas are more accessible, have better infrastructures and at present are more populous, the programme will inevitably have an important urban focus. However, it has become increasingly possible to work in rural areas, and a major aim will be to provide a balanced programme of urban and rural assistance.

30. Efforts will continue to achieve national coverage with selected key activities: EPI; CDD; distribution of micronutrient supplements, particularly vitamin A; supply of essential drugs; and strengthening of PHC centres. A wider range of interventions will be promoted at the subnational level as needs are identified and opportunities arise. Taking into account the background and attitudes of some ethnic and religious groups, it will be necessary to adopt different approaches in different areas, especially in relation to activities benefiting women and girls.

Health

31. The objective of the EPI project is to raise the level of coverage of children under one year of age to 60 per cent by 1994, immunizing 223,000 children from Kabul and 140,000 from Peshawar in 1992 and larger numbers in 1993 and 1994 if the political/security situation improves. In addition, it is intended to immunize annually 352,000 women between the ages of 15 and 44 years from Kabul and 450,000 between the ages of 5 and 44 years from Peshawar. The problem of inadequate coverage of women will be addressed by promoting the recruitment, training and placement of couples so that female vaccinators, working with their husbands, can help to overcome the cultural and religious barriers faced by the largely male teams; in addition, a special school-based health education activity will be initiated in urban areas.

32. Some 250 fixed EPI facilities will be supported in order to develop outreach to villages and communities in their catchment areas. In addition, 86 new, fixed centres will be established, while an estimated 150 mobile teams will operate in areas without fixed centres. Five regional cold stores will be set up to improve vaccine storage and distribution and solar refrigerators will be tested in 20 locations. The training of new staff, refresher training and active supervision will continue to be stressed. In order to encourage families to have their eligible members vaccinated, orientation will be organized for community leaders, schoolteachers, religious leaders and women's groups.

33. In the refugee camps in Pakistan, priority will be given to ensuring that infants are fully immunized by 12 months of age and that all pregnant women are adequately protect against tetanus.

34. The CDD programme will continue to promote proper case management and the timely use of ORS. Training will be organized for 750 health staff, as well as orientation for 600 schoolteachers, 750 drug retailers and 1,500 community and religious leaders and women's groups. A CDD awareness campaign will be undertaken during the peak diarrhoea season to intensify ongoing community education activity, reaching at least 7,500 mothers.

35. Annual production of ORS will be increased to 3 million packets in 1992. In addition to the normal distribution to health facilities, packets will be positioned in advance in regional storage centres prior to the peak diarrhoea seasons. Mobile vaccination teams will also carry a supply with them and will be trained to teach the communities about the importance of ORT and how to mix the packets. ORT corners will be set up in 110 urban and an estimated 45 rural health centres and will serve as distribution outlets for ORS, as well as referral points for severe cases of diarrhoea.

36. The ARI project will be expanded initially to Herat, Mazar, Jalalabad and Faizabad, benefiting 150,000 children, and then to other areas. Training will be carried out for 150 medical and paramedical personnel as a necessary step to combat inappropriate drug use and to encourage early diagnosis and effective management. Advocacy and the creation of public awareness will be important activities.

37. UNICEF will continue to support the gradual improvement of PHC services through the provision of medical supplies and equipment, including essential drugs. The objective is to reach 2.5 million children and women in 28 provinces. This will also mean expanding the number of health and MCH centres by repairing the physical infrastructure and by training staff. Some 1,200 health staff in both government- and mujahidin-controlled areas will be trained in various aspects of PHC, with an emphasis on MCH. In addition, 600 TBAs will be identified and given training and kits, while 900 primary and preschool teachers will be trained and supplied with first aid kits. Utilizing EPI and public health networks, 300,000 children under five years of age will receive vitamin A capsules and 450,000 pregnant women will receive iron and iodine supplements.

38. Increased emphasis will be placed on safe motherhood. Assistance will be provided to establish a referral system for maternity hospitals in Kabul and maternity units in provincial hospitals. Considerable support will be given for the production and dissemination of information, education and communication materials on the importance of antenatal and post-natal care, birth spacing and the prevention of high-risk pregnancies, in addition to immunization, ORT, ARI, breast-feeding, growth monitoring, hygiene and sanitation. An additional 9,000 copies of Facts for Life will be printed and distributed to schools and health centres; flip charts and leaflets will also be reproduced and emphasis will be put on increasing the spread of messages through radio and television.

Water supply and sanitation

39. The provision of safe water is an urgent and widespread need in both urban and rural areas. UNICEF will focus on repairing and rehabilitating water supply schemes initially in 12 provinces, as well as supporting the construction of new ones in communities that are prepared to share in the activities, especially future maintenance. Emphasis will also be placed on providing water to schools in urban areas and health institutions. In rural areas, UNICEF, in cooperation with UNDP, will provide safe water to some NGO health facilities with ORT corners and/or MCH activities; a significant health/hygiene education component will be built into the project.

40. To promote improved sanitation, 300 low-cost demonstration latrines will be constructed for poor families, and the summer campaign will be carried out in five provincial capitals. Some 180 technical, managerial and programme staff of the Rural Water Supply Department and a similar number from opposition-controlled areas will be trained in areas such as repair and maintenance, drilling and the design and construction of water supply and environmental sanitation systems. Some 750 community and religious leaders, teachers and health workers will receive orientation on the causes and prevention of water-borne and excreta-related diseases.

Nutrition

41. In order to begin combating child and maternal malnutrition, a comprehensive nutrition package, including growth monitoring, applied nutrition, selective food supplementation and intensive training and communication activities, will be designed and implemented initially in six districts where the problem is most serious. Emphasis will be placed on proper nutrition practices during antenatal care and on breast-feeding immediately after birth. Nutrition surveys will be carried out in six provinces in order to provide baseline data.

Basic education

42. Advocacy for education for all will continue with seminars for high-level policy makers and planners, followed by similar meetings at provincial and district centres. A joint UNESCO/UNICEF pilot scheme will develop life and skills-oriented education appropriate for Afghanistan. Initially, 50 basic education centres will be established in selected deprived areas of six provinces to serve 300,000 children. Communities willing to set up centres for both boys and girls, together or separately, will be given priority. The project will promote community ownership of educational institutions, which should provide both formal and non-formal education for the whole community and serve as social service delivery outlets as well as learning facilities. Teacher training and the local production of basic teaching and learning materials will also be stressed. In addition, 300 poor primary schools will be provided with essential equipment and supplies.

Women's development

43. UNICEF will consolidate its partnership with the women's groups and communities that it worked with in the previous planning period and also utilize the network of the Afghan Women's Council and the Afghan Women's Society to help solve the problems of the most disadvantaged women. To extend the programme, efforts will be made to identify key women and to train them to mobilize other women in their communities to contribute more actively to improving family welfare. In addition, activities will include home and community-based skills training, income generation and small food production, tree planting for firewood and ecological improvement, functional literacy programmes and humanitarian assistance for vulnerable women in time of crisis.

Children in especially difficult circumstances

44. In cooperation with ICRC, the League of Red Cross Societies, ARCS and the International Assistance Mission, UNICEF will provide assistance to some 3,000 disabled, abandoned and disadvantaged children in six provinces. Fifteen "drop-in" centres for street children will be established. They will provide health, recreation, skills training and counselling, in addition to two hot meals a day and washing facilities. Six provincial surveys of children in especially difficult circumstances will be carried out in collaboration with the ARCS community-based rehabilitation services for children, while a database will be established to collect, analyse and coordinate information and services for all problems affecting such children.

Emergency preparedness

45. Assuming continuing instability in the country, UNICEF will strengthen its capacity to respond rapidly to the needs of the most vulnerable groups by setting up three additional operational bases in Taloqan, Bamyan and Kandahar. The bases will improve access to rural areas and increase knowledge and understanding of the local situation. Early warning mechanisms will be established and supervised in collaboration with other United Nations agencies, and a contingency plan for the mass return of refugees will be worked out with UNHCR.

46. With bases in six locations inside Afghanistan and in Peshawar that include supply centres for the pre-positioning and distribution of essential commodities, UNICEF will strive to respond to emergencies as well as to support the delivery of services throughout the country.

Cooperation with other agencies

47. This relief and rehabilitation programme has been developed within the framework of the joint United Nations plan for humanitarian assistance for Afghanistan, coordinated by UNOCA. A major programme review exercise held at Islamabad in October 1991 brought togetther key staff of all the participating agencies of the United Nations system for the first time. The strategies of this programme have been widely shared, and links for cooperation and coordination with other United Nations agencies such as UNHCR, ILO, WHO, UNESCO, UNFPA and WFP have clearly been identified. NGOs working in both urban and rural areas will continue to be important partners of UNICEF in the Afghanistan programme.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Afghanistan (1990 and earlier years) UNICEF country classification

Under-five mortality rate	292	(1990)	Very high U5MR
Infant mortality rate	167	(1990)	Very high IMR
GNP per capita	$ 280	(1987)	Low GNP
Total population	16.6 Million	(1990)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1990
Births	(thousands)	716	789	735	888
Infant deaths (under 1)	(thousands)	142	144	131	148
Under-five deaths	(thousands)	250	253	229	259
Under-five mortality rate (per 1,000 live births)		349	320	311	292
Infant mortality rate (under 1) (per 1,000 live births)		199	183	178	167

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1980/1987)	Moderate & severe	38*	..
	Severe	7*	..
Babies with low birth weight (%, 1979/1987)		20*	20
% of primary school children reaching final grade (1980/1988)		54	78

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1980/1983)		../../..	../ 74a/ 61a
Prevalence of wasting (%, 1980/1985)		..	..
Prevalence of stunting (%, 1980/1985)		..	..
Daily per capita calorie supply (% of requirements, 1979-1981/1984-86)		94	94
Food production per capita index (Index 1979-1981=100, 1980/1990)		..	..
Household expenditure (% of total income, 1980-1985)	All food/cereals		../..

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1988-1989)			11
Access to health services	Total	..	29
(% of population, 1980/1985)	Urban/rural	../ ..	80/ 17
Access to safe water	Total	11	21
(% of population, 1980/1988)	Urban/rural	28/ 8	39/ 17
Access to adequate sanitation	Total	..	..
(% of population, 1980/1985)	Urban/rural	../ ..	5/ ..
Births attended by trained personnel (%, 1977/1989)		5	9*
Maternal mortality rate (per 100,000 live births, 1975/1989)		690	640*

Immunization		1981	1985	1990
One-year-olds (%) immunized against:	Tuberculosis	8	17	30
	DPT	3	15	25
	Polio	3	15	25
	Measles	6	14	20
Pregnant women (%) immunized against	Tetanus	3	11	3

/...

TABLE 1 (continued)

Afghanistan

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	33/ 29	25/ ..
(%, 1980/1988)	Male	54/ 46	33/ ..
	Female	12/ 11	17/ ..
Secondary enrolment ratio (gross/net)	Total	10/ ..	8/ ..
(%, 1980/1988)	Male	16/ ..	10/ ..
	Female	4/ ..	7/ ..
Adult literacy rate, 15 years & older	Total	8	29
(%, 1970/1990)	Male/female	13/ 2	44/ 14
Radio/television sets			
(per 1,000 population, 1980/1988)		75/ 3	102/ 8

DEMOGRAPHIC INDICATORS		1970	1980	1985	1990	2000**
Total population	(Million)	13.6	16.1	14.5	16.6	26.5
Population aged 0-15 years	(Million)	..	7.3	6.4	7.3	11.8
Population aged 0-4 years	(Thousands)	..	2650.0	2392.7	2963.2	4690.2
Urban population (% of total)		11	16	17	18	22
Life expectancy at birth	Total	37	40	41	43	47
(years)	Male	37	40	41	42	46
	Female	37	41	42	43	47
Total fertility rate		7.1	7.1	6.9	6.9	5.9
Crude birth rate (per 1,000 population)		52	50	49	51	43
Crude death rate (per 1,000 population)		27	24	23	23	18

		About 1980	Most recent
Contraceptive prevalence rate		2	..
(%, 1976)			
Population annual growth rate	Total	2.4	0.3
(%, 1965-1980/1980-1990)	Urban	6.0	1.8

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate		0.6	..
(%, 1965-1980)			
Inflation rate (%, 1965-1980/1980-1989)		5	..
Population in absolute poverty	Urban/rural	18/ 36	../ ..
(%, 1977/1988)			
Household income share	Top 20%/bottom 40%	../ ..	../ ..
(%, 1977/1988)			
Government expenditure	Health/education	../ ..	../ ..
(% of total expenditure, 1980/1989)	Defence	..	..
Household expenditure	Health/education		../..
(% of total income, 1980-1985)			
Official development assistance:	US$ millions	32	95
(1980/1989)	As % of GNP	2	..
Debt service			
(% of goods & services exports, 1980/1989)		..	..

a/ Kabul only.

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1990-1991

(In thousands of United States dollars)

COUNTRY: AFGHANISTAN
LATEST BOARD APPROVAL: 1990
GENERAL RESOURCES: $10,000,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Total
Health		46				7		5		58	58
Emergency	2528	5433	174	149	3558	884	1080	1339	7340	7805	15145
GRAND TOTAL	2528	5479	174	149	3558	891	1080	1344	7340	7863	15203

GR = General resources.
FSF = Funded supplementary funding.

TABLE 3. PLANNED EXPENDITURE, 1992-1994

(In thousands of United States dollars)

Country: AFGHANISTAN Period covered: 1992-1994	Funding status	1992	1993	1994	Total
Health	GR	2400	2425	2425	7250
	FSF	1600			1600
	NSF	3260	2750	2750	8760
Water supply and sanitation	GR	500	500	500	1500
	NSF	1630	2130	2500	6260
Nutrition	GR	250	250	250	750
	NSF	100	180	200	480
Education	GR	450	450	450	1350
	NSF	350	600	800	1750
Women-centred programme	GR	250	250	250	750
	NSF	300	450	450	1200
Children in especially difficult circumstances	GR	250	250	250	750
	NSF	250	500	500	1250
Emergency preparedness	GR	500	500	500	1500
	FSF	130			130
	NSF	500	500	200	1200
Programme support	GR	900	875	875	2650
	FSF	430			430
TOTAL	GR	5500	5500	5500	16500
	FSF	2160			2160
	NSF	6390	7110	7400	20900
GRAND TOTAL		14050	12610	12900	39560

GR = General resources.
NSF = New supplementary funding.
FSF = Funded supplementary funding.

TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: AFGHANISTAN	Number of posts	Amount (Thousands of United States dollars)
FINANCED FROM 1992-1993 APPROVED BUDGET:		
International Professional established posts	4	981
Local national Professional and General Service established posts	16	1398
Operating costs		593
Total	20	2972
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources	11	2554
Supplementary funds	3	556
Local national Professional and General Service project posts		
General resources	18	108
Supplementary funds	13	78
Total	45	3296

a/ For information source, see the 1992 revised post authorization table, dated 23 July 1991.

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Programme Committee
1992 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Bhutan

The Executive Director recommends that the Executive Board approve the country programme of Bhutan for the period 1992-1996 in the amount of $5,000,000 from general resources, subject to the availability of funds, and $8,200,000 in supplementary funds, subject to the availability of specific-purpose contributions.

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* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Financial adjustments, taking into account unspent balances of programme cooperation at the end of 1991, will be contained in the "Summary of 1992 recommendations for general resources and supplementary funding programmes" (E/ICEF/1992/P/L.2 and Add.1).

THE SITUATION OF CHILDREN AND WOMEN

1. Bhutan's economy is constrained by its mountainous terrain, a small and scattered population and a lack of skilled manpower. More than 90 per cent of the population derive their livelihood from agriculture and livestock production. Private enterprise is limited to a few small-scale industries, highlighting the country's narrow entrepreneurial base and explaining its dependence on external assistance. India is the main trading partner and absorbs much of Bhutan's timber, minerals, agricultural products and hydroelectric power.

2. During the 1980s, the gross domestic product grew at a rate of over 5 per cent annually, but unsustainable deficits in capital and recurrent budgets over the last few years have led the Government to impose severe budget reductions since 1991. Despite economic and political difficulties, the survival and well-being of children is given high priority. Allocations for social services will increase during the Seventh Five-Year Development Plan period (1992/93-1996/97), with the budget shares for health and education increasing from 4 to 6.7 per cent, and education from 8 to 11.2 per cent, respectively. A national plan of action for children is being prepared and most of the 1990s goals for this plan are also incorporated in the Seventh Five-Year Development Plan. The Government has ratified the Convention on the Rights of the Child and has signed the Declaration and Plan of Action of the World Summit for Children.

3. Bhutan remained isolated from the outside world until the 1960s. Since then, there has been enormous progress for children and women. Almost the entire population has access to modern health services, and most children are being immunized against the six vaccine-preventable childhood diseases. Primary education is provided for over half of school-age children and improved water supplies are available to 40 per cent of rural households. However, basic social indicators show that children and women still face many problems. It is estimated that out of every 1,000 live births, approximately 123 children die before their first birthday and another 66 die before their fifth birthday. Diarrhoeal diseases and acute respiratory infections (ARI) account for more than half of reported child morbidity and diarrhoea alone for more than 40 per cent of deaths among children. One underlying cause is a general lack of awareness of basic principles of hygiene and sanitation.

4. The maternal mortality rate (MMR) is one of the highest in the world at 770 per 100,000 live births. A major cause is that 90 per cent of the women deliver at home without support from trained personnel. There are no traditional birth attendants in Bhutan, and referral to the nearest hospital is difficult. Malnutrition is also a serious problem, with one out of every two children under five years of age below the required height for age and 38 per cent of children underweight for age. Among women of child-bearing age, 13 per cent are of low stature (below 145 centimetres), and 18 per cent are malnourished according to the body mass index. Anaemia is also a major

problem for women, and iodine deficiency disorders (IDD) and vitamin A deficiency are prevalent nationwide.

5. Although the availability of improved drinking water supplies has increased fivefold over the last decade, 60 per cent of rural households still do not have an improved water supply. Many of the existing water sources provide contaminated water, so only about 25 per cent of the rural population has access to safe drinking water. Approximately 60 per cent of rural households have a latrine, but only 15 per cent of these latrines are of an improved, more sanitary type.

6. While there are no major concerns exclusive to girl children which are not shared by boys, girls have less access to education - only 38 per cent of primary school students are female. Some 33 per cent of school-age children do not yet have access to education. Every year, some 30 per cent of students repeat their grade, and almost two thirds drop out before they reach the end of the primary education cycle. Thus, a large number of children are out of school, with very few opportunities to continue their basic education or to gain employment. Illiteracy among adults, at 30 per cent, is also a major problem, and less than 10 per cent of adult women are literate.

7. All of these problems are interlinked and reinforce each other. The population lives in remote isolated areas, difficult to reach with social services. Traditional beliefs further limit the use of existing services and, at the same time, people lack the basic knowledge to prevent illness through simple, personal hygiene interventions. In addition, at the same time that Bhutan aims to preserve its cultural heritage and natural resources, the kingdom has faced threats of ethnic and civil unrest along its southern border since 1990, adversely affecting schooling and health services for children living in these parts of the country.

PROGRAMME COOPERATION, 1986-1991

8. UNICEF assistance to Bhutan began in 1974. For the 1986-1991 programme of cooperation, the Executive Board approved a commitment of $2,850,000 from general resources and another $5,115,000 in supplementary funds, subject to the availability of specific-purpose contributions. The programme was implemented nationwide and focused on child survival, primary education, rural water supply and sanitation, programme communication and women in development.

Health

9. The health programme aimed at child survival through the control of vaccine-preventable and diarrhoeal diseases and at expanding the primary health care (PHC) network through the training of peripheral health workers, the provision of essential drugs and the construction of a basic health infrastructure. The global goal of universal child immunization (UCI) was reached in 1990, with complete coverage of 84 per cent of children under one

year of age and 63 per cent of pregnant mothers. The strategy of expanding the network of mobile outreach clinics led not only to the achievement of UCI, but also to access to health services for over 90 per cent of the population. The outreach clinics provide a package of PHC services to most villages on a monthly basis. The challenge is to expand coverage to unserved areas.

10. Packaged oral rehydration salts (ORS) are now used in 45 per cent of cases of diarrhoea, and homemade solutions in another 10 per cent. The introduction of oral rehydration therapy (ORT) training corners in all district hospitals and many basic health units contributed to the increase in ORS usage, as did the training of all peripheral health staff in ORT and the availability of ORS packages at all health facilities. In order to promote ORT further, mothers need to be better mobilized and trained.

11. UNICEF has also provided about 20 per cent of the annual requirements of essential drugs for the treatment of the most common childhood ailments. Bhutan has a good drug management system, and essential drugs are readily available at all health facilities. Support was provided to train some 30 health staff annually for the expanding network of PHC facilities. The Royal Institute of Health Sciences and its dormitories were constructed with UNICEF support, and handbooks were developed on child health and nutrition. Three rural basic health units and a paediatric and maternity ward were also constructed to expand the healthcare network. During the 1990 mid-term review, it was decided that UNICEF would phase out of construction of the health infrastructure.

Nutrition

12. The aim of the programme was to increase people's awareness of the need for improved feeding habits; to build up the capacity of health staff; and control micronutrient deficiencies in iodine, iron and vitamin A. Capacity-building has been slow to materialize and needs to be further developed, especially at the district level. The first step was taken, however, by producing manuals for agriculture and health field workers and teachers on nutrition, growth monitoring and weaning food. Although a national expanded programme on immunization (EPI) review in 1991 confirmed that the road-to-health card was available in every household with children below the age of two years old, the card is used mainly as an immunization and weight record. It will be necessary to train health workers to use monthly weight gain and loss as an educational tool to create awareness of appropriate feeding of small children.

13. Annual vitamin A requirements, iron and folic acid tablets and deworming tablets were made available to children and women through the health care network countrywide. However, the distribution of supplies was not properly linked to health education, except in five pilot districts, which showed much better results than the rest of the country. Every Bhutanese family now has access to adequate supplies of iodized salt from the national salt iodization plant. There is, however, still a need to increase people's awareness about

the importance of using iodized salt and proper storage practices to prevent the loss of iodine content. The impact of the IDD programme will be evaluated in 1992.

Rural water supply and sanitation

14. Since 1974, more than 1,300 water schemes have been constructed, serving approximately 40 per cent of the rural population. The accelerated training of technical staff, combined with project standardization, has improved the technical quality of water supplies in recent years, but at the same time it has slowed down implementation. A 1990 survey carried out by UNICEF consultants revealed that 16 per cent of the older schemes were out of order and 31 per cent required major repairs. Poor quality construction in earlier years and the lack of proper operation and maintenance were the major causes. An operation and maintenance policy was subsequently adopted and is gradually becoming operational.

15. UNICEF became involved in latrine construction only in 1991 when a rural sanitation programme was designed for the installation of 4,000 subsidized sanitary latrines in rural households and schools. However, health workers had already been promoting sanitation by encouraging people to use a fixed place for defecation, resulting in high coverage rates for simple pit latrines in some districts. Hygiene and sanitation promotion is part of the primary school curricula, but the students cannot practice their new knowledge since hygienic facilities are either unavailable or poorly maintained in schools.

Education

16. The education programme aimed at increasing primary school enrolment and improving the relevance of primary education. Based on recommendations made by UNICEF consultants in 1988, 1989 and 1990, the Government decided to change the status of a child-centred curriculum known as the new approach to primary education (NAPE) from a pilot project to gradual expansion throughout the country. Although UNICEF was not involved with the actual development of this curriculum, support was provided to facilitate the printing of textbooks for pre-testing purposes and to develop an in-house capacity in the layout and design of books. Another pilot project of small community schools was also accepted for nationwide expansion as a strategy to reach universal primary education by the year 2000.

17. A two-pronged approach was applied to increase access to education. First, the number of trained national primary school teachers increased from 75 to 150 annually owing to the construction of two dormitories at Paro Teacher Training College. Second, in addition to 12 boarding schools built under a World Bank-assisted project, UNICEF supported the construction of three primary boarding schools for 1,200 students in remote areas. During the mid-term review, it was decided that UNICEF would phase out of large-scale construction projects in the education sector.

Women in development

18. The National Women's Association of Bhutan (NWAB) and UNICEF carried out a study on the situation of the girl child which confirmed that there is no difference in the treatment of boys and girls before the age of six years. Disparities begin at the primary school age, with lower enrolment rates for girls than boys. Girls also drop out of primary school earlier than boys. UNICEF cooperated with NWAB in providing yarn to rural women to support income generation through traditional weaving. However, owing to the lack of a market outlet and regular follow-up, the majority of the weavers generated very little income, and the project was discontinued. The same women were also trained in kitchen gardening and provided with vegetable seeds. Although a proper evaluation was not carried out, it was observed that the majority of the 1,000 women reached by the project grew and consumed more vegetables. They also found a better market for the sale of vegetables than for their handicrafts. Nutrition education for rural women was later reinforced by introducing simple health, nutrition and hygiene messages, using Facts for Life. This pilot project proved that it is feasible to train illiterate women to become health communicators and leaders in their own communities. UNICEF also supported NWAB in installing over 13,000 smokeless stoves in rural households, aiming at reducing eye and respiratory infections. A 1990 survey carried out by UNICEF consultants found that 66 per cent of the stoves were not working properly or were not in use. In spite of this, the study concluded that smokeless stoves were indeed relevant for Bhutan, but further research was needed to determine the most appropriate types of stoves before expanding the programme.

Social mobilization

19. A successful beginning was made in mobilizing the influential Buddhist monks in support of health, nutrition and hygiene promotion at the village level using a national-language version of Facts For Life. The monastic body has subsequently produced dramas and plays on health issues which are shown during religious festivals. Annual immunization calendars and other communication materials were produced on health, nutrition and hygiene and sanitation messages. However, experience has shown that pre-testing techniques and follow-up must be improved to ensure that the predominantly illiterate population understands and uses the materials.

Lessons learned

20. Assessment of past experience indicates that effective community involvement is the key to ensuring sustainability. To achieve community involvement, social awareness and community mobilization are the proven modalities. For content and messages, the usefulness of Facts for Life is unquestioned. Strategies must address the needs of a largely illiterate population, for which the intercession of Buddhist monks becomes very relevant. The government service network and demand on staff for many of these services is expanding in areas such as maternal and child health (MCH)

and education. Support for training has become a basic requirement and a more strategic intervention than construction projects, which are better assisted by other donors. Instead of isolated sectoral projects, gains can be optimized by intersectoral links between health, education, water supply, and hygiene and sanitation.

RECOMMENDED PROGRAMME COOPERATION, 1992-1996

Recommended general resources: $5,000,000
Supplementary funds: $8,200,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health and nutrition	1 850	3 150	5 000
Rural water supply and sanitation	560	3 280	3 840
Basic education	1 240	1 770	3 010
Community action for basic services	160	-	160
Advocacy and social mobilization	440	-	440
Planning and monitoring	150	-	150
Programme support	600	-	600
Total	5 000	8 200	13 200

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

Programme preparation

21. The country programme was prepared jointly by the Planning Commission, sectoral ministries and UNICEF. The problems of children and women were discussed at a workshop in April 1990, in which central- and district-level government officials participated, as well as representatives of the United Nations and other international agencies. A situation analysis was carried out jointly during 1990, followed by another workshop in February 1991 to develop goals and strategies. These were used for the country programme, as well as for the Seventh Five-Year Development Plan and the national plan of action, which were under preparation during the same time period. A strategy meeting in May 1991 was followed by drafting of a plan of operations for cooperation during 1992-1996. This plan was reviewed during a preview meeting in October, which confirmed the thrust, strategies and activities of the proposed programme. Through joint United Nations programming discussions, the cooperation programmes of the United Nations Development Programme (UNDP), the World Health Organization (WHO), the United Nations Population Fund (UNFPA), the International Fund for Agricultural Development, the United Nations Capital Development Fund (UNCDF), the Food and Agriculture Organization of the United Nations (FAO), the World Food Programme (WFP) and UNICEF for the 1992-1996 period were developed in close collaboration.

National goals for children and women

22. Bhutan's national goals for children and women for the Seventh Five-Year Development Plan are: (a) to reduce infant and under-five mortality rates from 123 and 189 per 1,000 live births to 50 and 70 per 1,000 live births, respectively, and to reduce MMR by half from 770 to 385 per 100,000 live births; (b) to reduce moderate and severe protein energy malnutrition in children under five years of age from 38 per cent to less than 19 per cent, and among women, from 18 per cent to less than 12 per cent; (c) to increase access to and use of safe water in rural areas from 40 to 60 per cent of the population and to achieve universal access to latrines; (d) to increase access to and use of smokeless stoves from 8 to 15 per cent; and (e) to increase access to primary education from 67 to 85 per cent of school-age children (gross enrolment) and to bring the enrolment of girls almost equal to that of boys.

Programme objectives

23. The country programme objectives will support progress towards national goals by: (a) consolidating, strengthening and expanding the integrated delivery of MCH care to rural communities countrywide, reaching at least 85 per cent of the approximately 23,000 children born each year and their mothers with antenatal and post-natal care and immunization, as well as the 100,000 children below the age of five years and their mothers with information and measures to control diarrhoeal diseases, ARI and micronutrient deficiencies, and to stimulate child growth; (b) providing safe water supplies for 160,000 rural people, safe latrines for 11,000 rural households and

smokeless stoves for 6,000 households; (c) expanding the new primary school curriculum countrywide by providing textbooks for all students in the lower grades, training all teachers in the new curriculum and in multi-grade teaching techniques and expanding primary education through support to the network of 196 rural community one- and two-teacher schools; (d) providing the whole population with access to the necessary knowledge and skills for improving the well-being and health of their children; and (e) reinforcing systems for monitoring progress towards the national goals for children and women in the 1990s and strengthening community action in support of these goals.

Programme strategy

24. The central approach will be to concentrate support through three main channels: (a) coordinated delivery of national social service programmes at the community level; (b) organized community action, not only to promote the use of national services to the fullest, but also to complement these services with activities generated at the local level; and (c) social mobilization through information, education and communication activities for effective advocacy and informed participation at all levels. Women's and girls' concerns will be integrated in the various sectoral programmes to ensure that their gender-specific goals and strategies are addressed.

Health and nutrition

25. A major contributing factor to Bhutan's remarkable achievement of UCI has been the establishment of mobile outreach clinics in 350 clusters of villages nationwide. Health workers walk for hours, often through difficult terrain, to meet people at a halfway point during these monthly clinics. Gradually, a series of additional PHC services have been added to immunization, and the outreach clinics now provide villagers with a package of promotive, preventive and curative MCH care and nutrition interventions. Together with UNFPA, WHO and the Government of Denmark, among others, UNICEF will continue to support the strengthening and expansion of this community-based PHC network.

Child health

26. UNICEF will continue to support EPI, aiming at sustaining the present high immunization coverage of under-one-year-old children at 85 per cent and increasing tetanus toxoid vaccination of pregnant women from 63 per cent to at least 85 per cent. Achievement of programme goals requires sustained maintenance of the cold chain, an uninterrupted supply of vaccines and immunization equipment, as well as increased mobilization of the general population and health staff to identify pockets of the population that have not yet been reached.

27. A national programme will be established to control ARI. Training programmes will be developed to train voluntary village health workers, leaders of women's groups and peripheral health staff to identify better danger signs and ensure timely treatment. UNICEF will continue to provide antibiotics through the health care network and will support all training and health education activities, aiming at reducing child deaths caused by ARI by one third. ORS packages will also be made available in all villages to ensure universal access to, and correct use of, ORT to control diarrhoeal diseases in children under five years of age. An important strategy is to increase mothers' awareness of ORT in order to generate demand for prepackaged ORS. UNICEF will continue to provide annual ORS requirements and to pay for training costs, aiming at a reduction in diarrhoeal diseases in children from 16 to 10 per cent and in deaths caused by diarrhoea from 40 to 20 per cent.

Safe motherhood

28. The point of departure is to understand why more than 90 per cent of women prefer to deliver at home, unattended by a health worker. A nationwide study of women's knowledge, attitudes and practices related to pregnancy and delivery is expected to provide information that will be used to modify health education on safe motherhood and training programmes for village-based health workers and peripheral health staff. A key factor will be to increase health workers' skills and knowledge through pre- and in-service training since these workers, in turn, will train village women in basic maternal health principles and risk detection. Health workers will also be provided with maternity kits to assist during home deliveries.

29. The safe motherhood component of the programme aims at: (a) achieving universal understanding of the notion of a small and healthy family and of the need to avoid pregnancies that are too early, too late, too close and too many; (b) providing universal access for women to professional family planning and counselling methods (to be provided by UNFPA); (c) increasing from 10 to 50 per cent the number of deliveries attended by trained health workers, either in the home or in a referral health facility; (d) identifying high-risk pregnancies for referral; and (e) providing all pregnant women with the necessary information and means to deliver safely in order to reduce the risk factor of home deliveries. In an effort to increase antenatal and post-natal attendance by village women, UNICEF will provide support for local communities to construct and equip a small building in which to hold outreach clinics, which presently take place outdoors. An average of 25 outreach clinics will be upgraded each year. In addition, small waiting homes for high-risk pregnant women will be established near district hospitals to ensure safer deliveries. These waiting homes will be built by the communities, with support from the Government, UNFPA and UNICEF. The Government of Denmark, UNCDF and UNFPA will assume the previous role of UNICEF in expanding the network of basic health units.

Nutrition

30. Through the nutrition component of the programme, UNICEF will assist in the continued implementation of the intersectoral 1988 National Assembly resolution on nutrition. Health workers will be trained to better identify children and pregnant and lactating women at risk through action-oriented antenatal and post-natal care of women and growth monitoring of small children. They will provide the mother and her family with necessary advice and support to improve daily food habits. This includes the promotion of exclusive breast-feeding until the child is at least four months old and improved and more frequent weaning foods thereafter. When necessary, sufficient requirements of iron tablets and other micronutrients, such as vitamin A, will be provided through the outreach clinics. Deworming tablets will also be provided through these clinics and the schools. Distribution will be closely linked to sanitation and hygiene education. Since the daily diet consists mainly of rice and meat or milk products, kitchen gardening of beans, pulse and green leafy vegetables will be promoted by health and agriculture extension workers, teachers, NWAB and the Buddhist monastic body.

31. Aiming at virtually eliminating IDD, UNICEF will continue to support the national programme of salt iodization by providing potassium iodate, packing materials and spare parts to the national salt plant. A nationwide survey in 1992 will evaluate the impact of the IDD control programme since its beginning in 1984. Efforts will increase to create better awareness in the general population of the importance of consuming iodized salt and of proper storage in shops and households to avoid the loss of iodine. UNICEF and WHO will be the main partners in the field of nutrition.

Health promotion through monks

32. The rural population more often turns to religious people and traditional healers than to the modern health care network for advice on matters related to health, diseases and death. The Buddhist monastic body has recently involved itself in promoting improved health and hygiene practices and advising people to make use of available health services. The 3,000 Buddhist monks, who live in monasteries, will be sensitized to the need to improve their own knowledge, attitudes and practices in matters related to health, hygiene and sanitation and will learn how to communicate this new knowledge to the rural population. This education process is based on Buddhist religious scriptures and Facts for Life messages. Monastic schools and monasteries will be provided with improved water supply and sanitation facilities to create a more hygienic environment. The district-based monastic secretariats will subsequently train village-based lay monks and traditional healers, who have the most frequent contact with the general population.

Rural water supply and sanitation

33. UNICEF support will be provided to construct and rehabilitate gravity-flow water supplies in about 1,000 rural communities nationwide, covering 160,000 people. All sources of water supply systems will be tested for bacteriological contamination. The main strategy will be to organize and empower the community by establishing a village maintenance committee to ensure the community's full participation in deciding on water supply and sanitation schemes and, upon completion of these schemes, its sense of ownership and responsibility for operation and maintenance. The involvement of village women as committee members and water supply caretakers will be crucial. Furthermore, some 11,000 households will be assisted in constructing subsidized, improved or simple pit latrines, and 6,000 households will be assisted in installing subsidized, smokeless stoves for a more hygienic home environment. The entire population will also be reached through the radio and other media with basic hygiene messages on why and how to build simple pit latrines, the importance of protecting food and hand-washing and how to protect the village drinking water supply from pollution. This will reinforce forthcoming national legislation, which will make it mandatory for each village community to keep its environment clean and maintain the village water supply, and for each household to build and use a latrine. To maximize health impact, the delivery of services will be made to converge so that water supply, latrine and smokeless-stove construction and hygiene education will come together at the village level. Policies and procedures were recently formulated to ensure the provision of hygiene and health education at all new rural water supply and sanitation sites.

34. Improved hygiene practices can now be learned in school owing to the new primary education curriculum. An important element is training teachers in hygiene education. But without a proper water supply and sanitary latrines on the school premises, the theoretical knowledge gained by the students cannot be put into practice. Therefore, the programme will provide some 200 community schools, monastic schools and basic health units with water supplies, the means for proper sanitation and smokeless stoves. These institutes will be encouraged to adopt other sanitary measures, such as a waste disposal pit, improved compound drainage and a regular check on personal hygiene habits through child-to-child activities. The World Bank/UNDP regional advisory group will be an active partner in the rural water supply and sanitation programme, providing expertise to prepare a national plan for 1993-2002 and for programme assessment and evaluations. The United Nations Volunteer programme and the Netherlands Development Organization will provide technical support for programme implementation.

Basic education

35. Since the World Conference on Education for All, the Government has decided to expand the network of small, rural schools in remote isolated areas and to place the best teachers there. A community school is defined as one

that is built and supported by the village community, wherever a minimum of 30 students are found within a walking distance of less than one hour. The school is provided with basic learning materials and one or two teachers, who teach the children through the use of multi-grade grouping and organization. In the 196 existing and planned community schools, UNICEF support will be used to upgrade the skills of teachers in multi-grade teaching techniques, provide learning materials for students and supply roofing materials, when necessary, and teaching equipment. Special efforts will also be made to create "village readiness" by mobilizing community leaders and parents to send their children, especially girls, to school and to keep them there. This community involvement in education will give children living in isolated and extremely underserved areas a chance to go to school. Wherever possible, the community school will be linked with the monthly outreach health clinic. The United Nations Educational, Scientific and Cultural Organization (UNESCO) will help with literacy efforts. The World Bank and the Government of Switzerland will continue to assist the expansion of teacher-training facilities and of larger primary schools with boarding facilities. UNCDF will take over the previous role of UNICEF in this area. The Oxford Famine Relief Campaign will continue actively to support the school-gardening programme.

36. Bhutan has developed a child-centred approach to primary education using a nationally developed and relevant curriculum. This curriculum deviates from the traditional "talk-and-chalk" method of subject teaching, by teaching through grouping children and encouraging them to investigate and learn by doing. The immediate environment is used to teach science, integrating school gardening and health and hygiene education. Population education has also been incorporated. From 1991 to 1997, the curriculum is being expanded, grade by grade, to all primary schools. Together with the World Bank, the Government of Switzerland and international volunteer agencies, UNICEF will support the expansion of the curriculum by upgrading the skills of all teachers in the new curriculum, preparing new school textbooks to be made available to all primary schoolchildren and introducing continuous classroom assessment of children's achievement. The capacity of the education administrators in all 18 districts will be upgraded through distance education to improve service delivery in the education sector. These interventions are expected to increase the primary education retention rate from 35 to 60 per cent.

37. UNICEF will work with NWAB to expand the programme of training rural women in leadership skills and as health and hygiene promoters, using Facts for Life and emphasizing safe motherhood, ARI, ORT, hygiene and child growth. Starting in eastern Bhutan, approximately 900 village women will be trained nationwide, covering almost 20 per cent of the country's 5,000 villages. A pilot project will also be initiated to train some 40 young female school drop-outs annually in income-generating skills, such as weaving, and in basic MCH and hygiene principles.

Advocacy and social mobilization

38. The Government actively promotes community involvement in development planning and implementation and recently introduced the concept of block development committees, to be elected by the rural communities and to be established gradually in each of the country's 191 administrative blocks. UNICEF will help develop a local-level participatory mechanism by assisting the communities to organize, inform and activate themselves. This mechanism will be tested first in a few selected districts in eastern Bhutan, before expansion to other parts of the country. The village water supply or community school will be used as an entry point. Children in difficult circumstances will be identified through community action so that they can be reached through appropriate means.

39. All sectoral activities emphasize the role of communication as an essential means to involve and mobilize communities. The programme seeks to develop and strengthen capacity, both centrally and at the community level, to effectively communicate on issues concerning children and women and to mobilize communities for achieving the national goals. The objectives are to ensure the implementation of the national plan of action for children; to strengthen the social mobilization component of each programme sector; and to provide all government officials and village communities with access to the essential knowledge and skills necessary to improve the health and well-being of their families. All communications media and channels will be used, but primarily radio, interpersonal communication and visual materials, in view of the high illiteracy levels in the country. Community groups, especially of women, will be identified and assisted to form radio listeners' groups, which will be provided with subsidized radios through a revolving fund. Facts for Life will be printed in local languages and a facilitators' guide will be developed for use by teachers, religious and women's leaders and extension workers. Since there are no specialized communication planners or radio producers on education and health issues in Bhutan, some 10 staff from the Department of Information and Broadcasting will be trained through short-term courses abroad. The Government of Denmark and UNFPA will also support programme communication in the health field.

Planning and monitoring the 1990s goals

40. UNICEF will work with the Planning Commission to update and revise the national plan of action for children in the 1990s. The monitoring of progress, from year to year and by district and community, is a function central to the achievement of the goals for children in the 1990s. This function has two interrelated dimensions: (a) tracking progress in terms of programme performance towards the specific objectives of this country programme, for which each sectoral programme has an integral monitoring process and mechanism with its own set of process and impact indicators; and (b) monitoring changes in human and social indicators relevant to the goals of the decade. The frame of reference will be the national plan of action for

children, and overall monitoring responsibility will rest with the Planning Commission. UNICEF, together with the Government, WHO, UNDP, UNFPA and other partners, will participate in preparing an action plan for monitoring and evaluation. The approach will be based on building capacity for establishing a data collection system, initially for a limited number of indicators, which will be disaggregated by gender. Baseline data need to be established for these indicators, followed by regular updating to facilitate monitoring of trends. Periodic updates will be published on the situation of children and women in the country. Village- and block-level systems will be introduced for registering and using data. Government field staff will be trained in the use of the data they collect as a tool of programme management.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Bhutan (1990 and earlier years) UNICEF country classification

Under-five mortality rate	189	(1990)	Very high U5MR
Infant mortality rate	123	(1990)	Very high IMR
GNP per capita	$ 190	(1990)	Low GNP
Total population	1517.0 Thousands	(1990)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1990
Births	(thousands)	43	49	52	58
Infant deaths (under 1)	(thousands)	7	7	7	7
Under-five deaths	(thousands)	11	11	11	11
Under-five mortality rate (per 1,000 live births)		247	222	207	189
Infant mortality rate (under 1) (per 1,000 live births)		159	143	134	123

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1980/1988)	Moderate & severe	..	38a
	Severe	..	..
Babies with low birth weight (%, 1979/1987)		..	..
% of primary school children reaching final grade (1978/1988)		25*	..

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1980/1987)		../../..	90*/ 90*/ 90*
Prevalence of wasting (%, 1980/1989)		..	4a
Prevalence of stunting (%, 1980/1989)		..	56a
Daily per capita calorie supply (% of requirements, 1979-1981/1988)		..	..
Food production per capita index (Index 1979-1981=100, 1980/1990)		100	86
Household expenditure (% of total income, 1980-1985)	All food/cereals		../..

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1988-1989)			40
Access to health services	Total	..	65
(% of population, 1980/1987)	Urban/rural	../..	.. /..
Access to safe water	Total	7	32
(% of population, 1980/1990)	Urban/rural	50/ 5	60 / 30
Access to adequate sanitation	Total	..	10*
(% of population, 1980/1988)	Urban/rural	../ ..	50*/ 7*
Births attended by trained personnel (%, 1980/1988)		..	7
Maternal mortality rate (per 100,000 live births, 1979/1990)		..	1310

Immunization		1981	1985	1990
One-year-olds (%) immunized against:	Tuberculosis	36	38	99
	DPT	13	22	95
	Polio	11	22	95
	Measles	21	27	89
Pregnant women (%) immunized against	Tetanus	..	3	63

TABLE 1 (continued)

Bhutan

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	15/ ..	26/ ..
(%, 1980/1988)	Male	../ ..	31/ ..
	Female	../ ..	20/ ..
Secondary enrolment ratio (gross/net)	Total	../ ..	5/ ..
(%, 1980/1988)	Male	../ ..	7/ ..
	Female	../ ..	2/ ..
Adult literacy rate, 15 years & older	Total	..	38
(%, 1970/1990)	Male/female	../ ..	51/ 25
Radio/television sets			
(per 1,000 population, 1980/1988)		6/0	15/ ..

DEMOGRAPHIC INDICATORS		1970	1980	1985	1990	2000**
Total population	(Thousands)	1045.0	1245.0	1362.0	1517.0	1906.0
Population aged 0-15 years	(Thousands)	..	530.0	574.9	634.5	801.9
Population aged 0-4 years	(Thousands)	..	192.7	206.1	232.1	293.5
Urban population (% of total)		3	4	5	5	8
Life expectancy at birth	Total	41	45	47	49	53
(years)	Male	42	46	48	50	54
	Female	41	44	46	48	53
Total fertility rate		5.8	5.6	5.5	5.5	5.3
Crude birth rate (per 1,000 population)		41	40	39	38	37
Crude death rate (per 1,000 population)		22	19	17	16	14

		About 1980	Most recent
Contraceptive prevalence rate		..	..
(%, 1976/1987)			
Population annual growth rate	Total	1.6	2.0
(%, 1965-1980/1980-1990)	Urban	3.7	5.0

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate		..	7.4
(%, 1965-1980/1980-1990)			
Inflation rate (%, 1965-1980/1980-1989)		0	..
Population in absolute poverty	Urban/rural	../ ..	.. / ..
(%, 1977/1988)			
Household income share	Top 20%/bottom 40%	../ ..	.. / ..
(%, 1977/1988)			
Government expenditure	Health/education	../ ..	5*/ 8*
(% of total expenditure, 1980/1987)	Defence	..	..
Household expenditure	Health/education		.. / ..
(% of total income, 1980-1985)			
Official development assistance:	US$ millions	8	40
(1980/1989)	As % of GNP	8	..
Debt service			
(% of goods & services exports, 1980/1989)		..	..

a/ Aged 0-60 months.

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1986-1991

(In thousands of United States dollars)

COUNTRY: BHUTAN
LATEST BOARD APPROVAL: 1986
GENERAL RESOURCES: $2,850,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Total
Health	528	462	44	67	68	262	148	539	788	1330	2118
Water supply and sanitation	4	3445		153	237	99	111	159	352	3856	4208
Nutrition	81	351		43			1	93	82	487	569
Education	38	122	38	1		136	279	272	355	531	886
Community organization and development	63		31		1		4	19	99	19	118
Women-centred programme	14	15	5				63		82	15	97
Advocacy	34	4					14		48	4	52
Planning and project support	116	47			195		32	2	343	49	392
Freight	116						21		137		137
GRAND TOTAL	994	4446	118	264	501	497	673	1084	2286	6291	8577

GR = General resources.
FSF = Funded supplementary funding.

TABLE 3. PLANNED EXPENDITURE, 1992-1996

(In thousands of United States dollars)

Country: BHUTAN Period covered: 1992-1996	Funding status	1992	1993	1994	1995	1996	Total
Health and nutrition	GR	400	400	350	350	350	1850
	FSF	182					182
	NSF	630	630	630	630	630	3150
Rural water supply and sanitation	GR	120	120	100	100	120	560
	FSF	840	893				1733
	NSF		410	950	940	980	3280
Basic education	GR	230	230	270	260	250	1240 a/
	FSF	228					228
	NSF	440	340	330	330	330	1770
Community action for basic services	GR	30	30	30	40	30	160
Advocacy and social mobilization	GR	70	70	100	100	100	440
Planning and monitoring	GR	30	30	30	30	30	150
Programme support	GR	120	120	120	120	120	600
TOTAL	GR	1000	1000	1000	1000	1000	5000
	FSF	1250	893				2143
	NSF	1070	1380	1910	1900	1940	8200
GRAND TOTAL		3320	3273	2910	2900	2940	15343

GR = General resources.
NSF = New supplementary funding.
FSF = Funded supplementary funding.
a/ In addition, $250,000 was allocated from global funds for education programme.

TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: BHUTAN	Number of posts	Amount (Thousands of United States dollars)
FINANCED FROM 1992-1993 APPROVED BUDGET:		
International Professional established posts	2	406
Local national Professional and General Service established posts	4	55
Operating costs		211
Total	6	672
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources	2	458
Supplementary funds	3	675
Local national Professional and General Service project posts		
General resources	5	25
Supplementary funds	2	10
Total	12	1168

a/ For information source, see the 1992 revised post authorization table, dated 23 July 1991.

Annex

LIST OF STUDIES AND EVALUATIONS

1. Inventory study of rural water supply projects in nine dzongkhags. East Consult, UNICEF consulting firm, 1990.

2. Universal child immunization in Bhutan. The Royal Government of Bhutan, UNICEF and WHO, 1991.

3. Multi-grade organization for community schools in Bhutan: Implications for pre-service and in-service training. UNICEF consultant, 1991.

4. The situation of the girl child in Bhutan. U. Wikan, UNICEF consultant, 1991.

5. Child mortality survey. Central Statistical Office and UNICEF, 1991.

6. National survey on drop-outs, non-enrolment and repetition in primary education in Bhutan. Department of Education and UNICEF, 1991.

7. Communicating with pictures in Bhutan. Peter Chen, UNICEF, 1991.

8. Results of 1989 fact-finding mission on traditional beliefs related to health and hygiene. F. Barth and U. Wikan, UNICEF consultants, 1989.

9. Evaluation of the yarn distribution for income-generating in Shemgang district. T. Hozumi, UNICEF, U. Rapten, NWAB, 1990.

10. Evaluation of the extended classrooms. B. Harley, UNICEF consultant, 1990.

11. Little holes for little people. K. R. Gibbs, UNICEF, S. N. Rai, Royal Government of Bhutan, 1990.

12. Report on the evaluation of the use of smokeless stoves. Dr. K. C. Khandelwal, UNICEF consultant, and M. J. M. De Boer, 1990.

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14. Evaluation of the UNDP-funded low-cost sanitation programme, 1985-1989. Mr. V. Venugopalan, 1990 UNDP consultant, and Ms. Moniek De Boer, UNICEF consultant, 1990.

15. Implementation of EPI information system in Bhutan. D. Gupta, UNICEF/WHO consultant, 1990.

16. Finnish International Development Agency (FINNIDA) evaluation of primary health care infrastructure. Dr. M. Vienonen, Dr. D. Samarasinghe, FINNIDA consultants, and M. Buchholz, UNICEF, 1989.

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22. Country programme for Bhutan's children, 1992-1996, goals and strategies. Royal Government of Bhutan and UNICEF, 1991.

23. A programme for Bhutan's children and women, 1992-1996. Plan of Operations. Royal Government of Bhutan and UNICEF, 1991.

24. Draft seventh five-year development plan, 1992-1997. Royal Government of Bhutan, 1991.

25. "Bhutan" in the Far East and Australia, 1991. Brian Shaw.

26. The Europa World Year Book, 1991, vol. 1.